

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365632	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER Majora Lane Ctr for Rehab & Nsg Care Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 105 Majora Lane Millersburg, OH 44654	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50536</p> <p>Based on observation, record review, facility policy review and interview the facility failed to prevent a potential accident hazard when a compressed gas cylinder (oxygen tank) was not properly stored/secured in Resident #34's room. This affected one resident (#34) of 58 residents residing in the facility.</p> <p>Findings include:</p> <p>Record review revealed Resident #34 was admitted to the facility on [DATE] with diagnoses including pneumonia, major depressive disorder, chronic kidney disease, diabetes, and osteoarthritis.</p> <p>Review of the physician's orders for Resident #34 revealed on 10/03/23 an order was obtained for continuous oxygen at two liters per minute via nasal cannula. The order was discontinued on 08/23/24.</p> <p>An observation on 09/23/24 at 11:38 A.M. revealed an unsecured oxygen tank leaning against the wall of the closet in Resident #34's room.</p> <p>Interview with Housekeeper #506 on 09/23/24 at 11:39 A.M. revealed oxygen tanks were not normally stored in resident's rooms without being in a storage cart.</p> <p>Interview with Registered Nurse (RN) #305 on 09/23/24 at 11:40 A.M. confirmed oxygen tanks should be stored in a locked room, upright, and in a storage rack when not in use. RN #305 verified the oxygen tank in Resident #34's closet was stored improperly, and should have been removed from the room when Resident #34's physician's order for oxygen was discontinued.</p> <p>Review of the facility's oxygen storage policy titled Altercare Safety Rules For Compressed Gas Cylinders revealed oxygen tanks should be stored in a well ventilated, protected area, and should be secured by a chain, strap, or on a cart, regardless of the size of the tank.</p> <p>Review of a document titled: Staff Development Sign-In Sheet revealed on 12/21/23 (untimed) a staff in-service was held that was titled: Compressed Gas Cylinders - Oxygen Tanks. The text on the document read, Please review the safety rules for compressed gas (oxygen tanks) to ensure proper handling and was signed by 15 staff with clinical titles.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015</p> <p>Based on observation, interview, and facility policy review, the facility failed to ensure appropriate food storage in the kitchen's dry storage area. Additionally, the facility failed to ensure the Robo-coupe (food processor) was clean and dry prior to pureeing Resident #21 and #23 meals and ensure a contained spoon was not placed into the mixture. This affected two residents (#21 and #23) and had the potential to affect 56 of 56 residents who received meals from the kitchen. The facility identified two residents (#1 and #30) who received nothing by mouth (NPO) and had NPO diet orders The facility census was 58.</p> <p>Findings include:</p> <p>1. Observation on [DATE] at 8:10 A.M. of the facility's dry food storage in the kitchen revealed six loafs of expired wheat bread. The expiration date was noted to be [DATE]. Upon further examination all six loafs of bread were observed to have visible mold growing on the bread.</p> <p>Interview on [DATE] at 8:10 A.M. Dietary Coordinator (DC) #507 confirmed the findings and removed the bread from the storage areas. Continued interview with DC #507 revealed all residents would have the potential to receive this bread except for Resident #1 and Resident #30 who did not receive any food by mouth.</p> <p>Review of the undated facility policy titled Dry Storage and Supplies revealed all non-perishable food shall be stored in a manner that optimized food safety and quality. Stock in dry storage (areas) shall be rotated such that new deliveries are placed behind existing stock.</p> <p>2. Observation on [DATE] at 10:15 A.M. revealed [NAME] #415 washed her hands and prepared to puree au gratin potatoes. After ensuring a proper consistency she placed the potatoes into a serving dish and took the food item to the steam table. She returned and placed the Robo-coupe in the facility high temperature dish washer at 10:22 A.M. [NAME] #415 returned with the Robo coupe which was observed to still wet from the dishwasher placed it on the counter. Remains of visible mashed potatoes could be seen on the side of the Robo-coupe. [NAME] #415 then placed meatloaf, beef broth, and bread into the machine and pureed until it met the correct consistency. She placed the puree meatloaf into a serving dish and took it to the steam table. At 10:26 A.M. the Robo-coupe was taken to the dishwasher. At 10:27 A.M. it was brought back to the counter with visible signs of wetness and [NAME] #415 placed mixed vegetables, bread and margarine into the machine to blend. After the mixture was blended, [NAME] #415 placed the mixed vegetables into serving dish and taste tested the mixture with a plastic spoon. After placing the spoon in her mouth to test the food she placed the same plastic spoon into the mixture and stirred the vegetables checking the consistency. After stirring the mixture with the dirty spoon, she went to place it on the steam table to be served.</p> <p>Interview on [DATE] at 10:27 A.M. with Dietary Coordinator (DC) #507 (who was present for the observation) and [NAME] #415 confirmed the Robo-coupe was not properly cleaned and left to air dry prior to pureeing the meat loaf and mixed vegetables. Both also confirmed [NAME] #415 placed her spoon into the vegetable mixture after it was already in her mouth. DC #507 revealed the facility had two residents who received puree meals (Resident #21 and Resident #23).</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the facility policy titled Puree Diets, dated ,d+[DATE] revealed puree food was to be prepared in a clean food processor for each item being prepared. Puree items were to be taste tested to ensure that the consistency was correct and hold their shape.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015</p> <p>Based on observation, interview, record review, and policy review the facility failed to ensure Enhanced Barrier Precautions (EBP) were in place while completing wound care for Resident #27. This affected one resident (#27) of one resident observed for wound care. The facility census was 58.</p> <p>Findings Include:</p> <p>Review of the medical record for Resident #27 revealed an admitted [DATE]. Diagnoses include a Stage III pressure ulcer to the residents left buttock, Alzheimer's Disease, and acute respiratory failure with hypoxia.</p> <p>Review of Resident #27's September 2024 physicians orders revealed an order for use Enhanced Barrier Precautions for pressure injury on left buttock.</p> <p>Review of Resident #27's care plan dated 09/23/24 revealed the resident required enhanced barrier precautions related to a chronic wound (pressure ulcer). Interventions involved EBP supplies to be placed in resident room, post signage to alert caregivers of the need for enhanced barrier precautions, and utilize the use of personal protective equipment (PPE) gowns and gloves during high contact resident care activities when in room, shower room, or in therapy.</p> <p>Observation on 09/24/24 at 2:50 P.M. revealed a sign outside of Resident #27' room stating to wear a gown and gloves for high contact care areas including wound care.</p> <p>Observation on 09/24/24 at 2:56 P.M. revealed Licensed Practical Nurse (LPN) #205 and Assistant Director of Nursing (ADON) #225 entered into the resident's room to perform wound care. LPN #205 and ADON #225 washed their hands and applied gloves but did not apply gowns. While LPN #205 assisted with holding the resident on his side and removing his brief, ADON #225 cleansed the residents wound (approximately a two inch linear Stage III pressure ulcer located on the resident's left buttock) and applied Triad Cream. LPN #205 reapplied the brief and assisted with positioning while ADON #225 completed hand hygiene and cleaned up the area.</p> <p>Interview on 09/24/24 at 03:16 P.M. with both LPN #205 and ADON #225 verified they did not apply gowns prior to or during Resident #27's wound care. Each nurse revealed although there was a sign outside the residents door and PPE in the resident's room they forgot to apply/DON their gowns.</p> <p>Review of the facility policy, Enhanced Barrier Precaution updated 04/01/24 revealed the facility would utilize enhanced barrier precautions as part of there infection prevention and control program to help prevent the development and transmission of communicable disease and infections. EBP were used in conjunction with standard precautions and extend the use of PPE to donning of gowns and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. EBP were indicated for residents with any of the following including chronic wounds and indwelling medical devices even if the resident was not known to be infected or colonized with MDRO. Examples of chronic wounds include pressure ulcers, diabetic foot ulcers, and unhealed surgical wounds.</p>		